State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495410	A. BUILDING _____ B. WING _____	11/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLEIGH BURKE PAVILION	1739 KIRBY ROAD MC LEAN, VA 22101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000		

An unannounced biennial State Licensure survey was conducted 11/15/16 through 11/16/16 Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 49 certified bed facility was 46 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents 1 through 11) and 4 closed record reviews (Residents 12 through 15).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5 - 371 - 340 - cross references to the federal deficiency 371

12 VAC 5 - 371 -180C (9)- cross references to the federal deficiency 469

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE